ATTACHMENT TO QIO MANUAL CHAPTER 7 TOPS MEMO

Overview of Chapter 7 Review Requirements: BIPA Reviews, Grijalva Reviews, Weichardt Reviews, Hospital-Requested Reviews, Preadmission HINN Reviews, Admission HINN Reviews, and HINN-11 Reviews

NOTE: The terms "BIPA Review," "Grijalva Review," and "Weichardt Review" are for use only in QIO internal communication and in communication with CMS, other QIOs, and other QIO Program contractors.

	BIPA Reviews	**Grijalva Reviews**	**Weichardt Reviews for Fee-for-Service Beneficiaries**	**Weichardt Reviews for Medicare Health Plan Enrollees**	**Hospital-Requested Reviews**	**Preadmission HINN Reviews and Admission HINN Reviews**	**HINN-11 Reviews**
Context	Fee-for-service (FFS)	Managed care	FFS	Managed care	FFS and managed care	FFS	FFS
Who Can Request QIO review	• FFS beneficiary • Beneficiary's representative • Medicare health plan enrollee receiving hospice benefits under FFS Medicare Part A	• Medicare health plan enrollee • Enrollee's representative	• FFS beneficiary • Beneficiary's representative	• Medicare health plan enrollee • Enrollee's representative	Hospital For a Medicare health plan enrollee, the hospital is expected to consult with the Medicare health plan before requesting QIO review. Review requests are accepted during the QIO's normal business hours.	• FFS beneficiary • Beneficiary's representative	• FFS beneficiary • Beneficiary's representative • Medicare Appeals Council
Service(s)	• Medicare-covered SNF services • Hospital swing bed under Part A SNF-level services • Hospice	• Medicare-covered SNF services • Hospital swing bed under Part A • Medicare-covered CORF services (if certification of	Inpatient hospital	Inpatient hospital	Inpatient hospital	Inpatient hospital	Inpatient hospital

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	under Part A (for both FFS beneficiaries and Medicare health plan enrollees), including hospice patients who dispute termination of hospice benefit • Medicare-covered CORF services (if certification of risk obtained) • Home health services under Part A or B and under a plan of care (if certification of risk obtained)	risk obtained) • Home health services under Part A or B and under a plan of care					
1st Notice: Title and Form Number	Notice of Medicare Provider Non-Coverage CMS-10123	Notice of Medicare Non-Coverage CMS-10095-NOMNC	An Important Message from Medicare about Your Rights CMS-R-193	An Important Message from Medicare about Your Rights CMS-R-193	Notice of Hospital-Requested Review HINN-10	Preadmission Hospital-Issued Notice of Noncoverage: Admission Hospital-Issued Notice of	HINN-11

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						Noncoverage	
1st Notice: Informal Name	Generic notice; NOMPNC	Advance notice; NOMNC	Important Message; IM	Important Message; IM	HINN-10	Preadmission HINN; Admission HINN	HINN-11
Who Issues 1st Notice?	Provider	Medicare health plan, or provider by delegation	Hospital	Medicare health plan, or hospital by delegation	Hospital	—	Hospital
Timing of 1st Notice	Provider must issue generic notice no later than 2 calendar days before proposed end of services unless services have been terminated abruptly or services are expected to be shorter than 2 days in duration or span of time between services exceeds 2 days. If services expected to be less than 2 days in duration, notice must be given at time of admission. If span of time between	Plan or provider must issue advance notice no later than 2 calendar days before proposed end of services unless services have been terminated abruptly or services are expected to be shorter than 2 days in duration or span of time between services exceeds 2 days. If services expected to be less than 2 days in duration, notice must be given at time of admission. If span of time between services exceeds 2 days, notice must be given no later than the next-to-last time services are	Hospital must issue IM no later than 2 calendar days following admission, unless given at preadmission or pre-registration. If given at preadmission or pre-registration, must not be given more than 7 calendar days prior to admission and a follow-up IM must be given no later than 2 calendar days before planned date of discharge. For abrupt or same-day discharges, hospital should issue IM at least 4 hours before discharge. See §7340.2(B) re:	Plan or hospital must issue IM no later than 2 calendar days following admission, unless given at preadmission or pre-registration. If given at preadmission or pre-registration, must not be given more than 7 calendar days prior to admission and a follow-up IM must be given no later than 2 calendar days before planned date of discharge. For abrupt or same-day discharges, hospital should issue IM at least 4 hours before discharge.	When hospital determines that patient no longer needs inpatient care but hospital is unable to obtain physician agreement.	QIO does not monitor timing of notice delivery. Timing of admission HINN affects beneficiary liability.	QIO does not monitor timing of notice delivery.

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	services exceeds 2 days, notice must be given no later than the next-to-last time services are furnished.	furnished.	discharges against medical advice.	See §7370.2(B) re: discharges against medical advice.			
What to Do if 1st Notice Is Invalid	If error has potential to impact patient liability: QIO notifies provider and beneficiary/representative of invalid notice and discontinues review unless new, valid notice is immediately issued and signed. If error is not significant: QIO instructs provider to reissue notice but this does not delay the review process.	If error has potential to impact patient liability: QIO notifies Medicare health plan, provider, and enrollee/representative of invalid notice and discontinues reviewunless new, valid notice is immediately issued and signed. If error is not significant: QIO instructs provider to reissue notice but this does not delay the review process.	If error has potential to impact patient liability: QIO instructs hospital to reissue notice and to adjust planned discharge date if necessary; review discontinued unless new, valid notice is immediately issued and signed. If error is not significant: QIO instructs hospital to reissue notice but this does not delay the review process.	If error has potential to impact patient liability: QIO instructs plan/hospital to reissue notice and to adjust planned discharge date if necessary; review discontinued unless new, valid notice is immediately issued and signed. If error is not significant: QIO instructs plan/hospital to reissue notice but this does not delay the review process.	—	—	—
2nd Notice: Title and Form Number	Detailed Explanation of Non-Coverage	Detailed Explanation of Non-Coverage	Detailed Notice of Discharge CMS-10066	Detailed Notice of Discharge CMS-10066	—	—	—

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	CMS-10124	CMS-10095-DENC					
2nd Notice: Informal Name	Detailed notice; DENC	Detailed notice; DENC	Detailed notice	Detailed notice	—	—	—
Who Issues 2nd Notice?	Provider	Medicare health plan or provider by delegation	Hospital	Medicare health plan or provider by delegation	—	—	—
Timing of 2nd Notice	QIO's normal close of business on day that QIO notifies provider that beneficiary/representative has filed review request.	QIO's normal close of business on day that QIO notifies Medicare health plan that enrollee/representative has filed review request.	See above and §7340.2(B) re: follow-up copy of IM. Hospital must issue detailed notice no later than noon of the calendar day after the QIO notifies the hospital that beneficiary/representative has filed review request.	See above and §7370.2(B) re: follow-up copy of IM. Plan or hospital must issue detailed notice no later than noon of the calendar day after the QIO notifies plan/hospital that enrollee/representative has filed review request.	—	—	—
What to Do If 2nd Notice Is Invalid	QIO continues review using available information.	QIO continues review using available information.	QIO continues review using available information.	QIO continues review using available information.	—	—	—
Deadline for Requesting QIO Review	Expedited review: noon of the calendar day preceding the effective date on the generic notice. See §7120.2 for deadline when coverage	Noon of the calendar day preceding the effective date on the advance notice. See §7220.2 for deadline when coverage ends abruptly.	Expedited review: midnight of the planned discharge date. Non-expedited review (untimely request) when beneficiary remains an inpatient: any time during the	Expedited review: midnight of the planned discharge date. No option for non-expedited QIO review.	Same as for IM	Expedited review for Preadmission HINN: QIO's normal close of business on the 3rd calendar day after the beneficiary received the HINN, including weekends and	—

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	ends abruptly. Non-expedited review: within 60 days of effective date.		hospitalization. Non-expedited review (untimely request) when beneficiary is no longer an inpatient: 30 calendar days after discharge, or at any time for good cause; see Appendix 7-2.			holidays Expedited review for Admission HINN: Any point during the hospital stay Non-expedited review: QIO's normal close of business on the 30th calendar day after receipt of the HINN	
Is Certification of Risk Required?	For CORF or HHA, a physician (or NP or PA acting under physician's direction) must certify that failure to continue service(s) may place the beneficiary's health at significant risk.	Not required	Not required	Not required	—	—	—
Who is Responsible for Providing Medical Records?	Provider	Medicare health plan, or provider by delegation	Hospital	Medicare health plan, or provider by delegation	Hospital	Hospital	Hospital
How to Deal with Missing, Incomplete, or	QIO issues technical denial to swing bed	QIO decides whether to proceed with	QIO issues technical denial.	QIO decides whether to proceed with	QIO decides whether to proceed with	—	—

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Illegible Medical Records	provider; for other settings, QIO notifies Project Officer. QIO decides whether to proceed with available information or defer review decision until additional information received, but deadline for QIO review decision does not change. Provider may be financially liable if covered services continue past effective date; see §7130.3.	available information or defer review decision until additional information received, but deadline for QIO review decision does not change. Medicare health plan may be financially liable if covered services continue past effective date; see §7230.3.	QIO decides whether to proceed with available information or defer review decision until additional information received, but deadline for QIO review decision does not change. Hospital may be financially liable if covered services continue past planned discharge date; see §7340.3.	available information or defer review decision until additional information received, but deadline for QIO review decision does not change. Hospital may be financially liable if covered services continue past planned discharge date; see §7370.3.	available information or defer review decision until additional information received, but deadline for QIO review decision does not change.		
Solicitation of Views	Provider uses detailed notice to explain termination/discharge. QIO interviews beneficiary/ representative. QIO provides	Provider uses detailed notice to explain termination/discharge. QIO interviews enrollee/ representative. QIO provides	Hospital uses detailed notice to explain discharge. QIO interviews beneficiary/ representative. QIO provides opportunity for hospital to explain	Medicare health plan or hospital by delegation uses detailed notice to explain discharge. QIO interviews enrollee/ representative. QIO provides	QIO interviews beneficiary/ representative. QIO provides opportunity for hospital to explain why discharge is appropriate.	QIO interviews beneficiary/ representative. QIO provides opportunity for hospital to explain why admission is not necessary.	—

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	opportunity for practitioner to explain why termination/ discharge is appropriate.	opportunity for practitioner to explain why termination/ discharge is appropriate.	why discharge is appropriate.	opportunity for plan/hospital to explain why discharge is appropriate.			
Deadline for QIO Review Decision	Expedited review: 72 hours after receipt of review request (or 72 hours after receipt of physician certification if required). Non-expedited review when beneficiary is still receiving services: QIO's normal close of business on 7th calendar day after QIO receives review request. Non-expedited review when beneficiary is <u>not</u> still receiving services: QIO's normal close of business on 30th calendar	QIO's normal close of business on next calendar day after QIO receives all necessary information.	Expedited review: QIO's normal close of business on the next calendar day after QIO receives all necessary information. Non-expedited review (untimely request) when beneficiary remains an inpatient: QIO's normal close of business on the 2nd calendar day after the QIO receives all necessary information. Non-expedited review (untimely request) when beneficiary is no longer an inpatient: QIO's normal close of business on 30th calendar day after QIO receives all necessary information.	Expedited review: QIO's normal close of business on the next calendar day after QIO receives all necessary information No option for non-expedited review.	QIO's normal close of business on the 2nd working day (Monday through Friday, excluding holidays) after the QIO receives both the review request <u>and</u> all necessary information from the hospital	Expedited review: QIO's normal close of business on 2nd working day (Monday through Friday, excluding holidays) after receipt of all information needed to complete the review Non-expedited review: Written notification postmarked by QIO's normal close of business on 30th calendar day after receipt of all information needed to complete the review (telephone notification not required)	—

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	day after QIO receives review request.						
Whom to Notify of Review Decision	QIO notifies beneficiary/representative, provider, and practitioner by phone, followed by written notice. Non-appointed or non-authorized representative does not receive written notification and only receives review decision, information on liability, and information on reconsideration rights.	QIO notifies enrollee/representative, plan/provider by phone, followed by written notice. Non-appointed or non-authorized representative does not receive written notification and only receives review decision, information on liability, and information on reconsideration rights.	QIO notifies beneficiary/representative and hospital by phone, followed with written notice. Non-appointed or non-authorized representative does not receive written notification and only receives review decision, information on liability, and information on reconsideration rights.	QIO notifies enrollee/representative, plan, and hospital by phone, followed by written notice. Non-appointed or non-authorized representative does not receive written notification and only receives review decision, information on liability, and information on reconsideration rights.	QIO notifies beneficiary/enrollee/representative, plan/provider by phone, followed by written notice.	QIO notifies beneficiary/representative and hospital by phone, followed by written notice.	—
Who Processes Reconsideration Reviews/Appeals	QIC	QIO	Timely reconsideration request when beneficiary is still an inpatient: QIO. Timely reconsideration request when beneficiary has been discharged:	Timely reconsideration request when enrollee is still an inpatient: QIO. Timely reconsideration request when enrollee has been discharged: refer	Same as FFS Weichardt	Same as FFS Weichardt	Standard Medicare claims appeal process

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			Administrative Law Judge, Medicare Appeals Council, or federal court. Untimely reconsideration request: Administrative Law Judge, Medicare Appeals Council, or federal court.	enrollee to Medicare health plan for information on appeal rights. Untimely reconsideration request: no reconsideration option.			